



**PROFESSIONAL/DENTAL CLAIM DOCUMENTATION
REVIEW AREA
FAX COVER
FAX: 866-584-8081**

TO: Professional Claims Review Unit, Medicaid Payments Division-Claims Processing
Bureau of Medicaid Financial Management, Medical Services Administration
Department of Community Health, State of Michigan

Completion of all highlighted fields is required.

FROM:

Group/Individual Name:

NPI Number:

Provider Type and ID Number, if
applicable: (i.e., TTDDDDDDDD)

Patient Medicaid ID Number:

Date of Service:

Contact Person Name/ Position:

Contact Person's Phone Number:

Contact Person's Fax Number:

**Number of Pages (Including Cover
Page):**

**DOCUMENTATION TYPE INCLUDED
(Check All that Apply)**

- | | |
|---|--|
| <input type="checkbox"/> AMBULANCE INFORMATION | <input type="checkbox"/> MEDICARE EOB AND/OR OTHER INSURANCE INFORMATION |
| <input type="checkbox"/> BILLING TIME LIMIT/REMITTANCE ADVICE/CRN'S | <input type="checkbox"/> NDC DRUG DOSING AND COST INFORMATION |
| <input type="checkbox"/> HIGH COST CHARGES MANUFACTURER INFORMATION | <input type="checkbox"/> PRIOR AUTHORIZATION |
| <input type="checkbox"/> MEDICAL RECORDS | <input type="checkbox"/> INFORMED CONSENT TO STERILIZATION (MSA-1959) |
| <input type="checkbox"/> ADMIT/DISCHARGE REPORT | <input type="checkbox"/> ABORTION FORMS (MSA-4240 & MSA-1550) |
| <input type="checkbox"/> ER REPORT | <input type="checkbox"/> ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION (MSA-2218) |
| <input type="checkbox"/> HISTORY AND PHYSICAL | |
| <input type="checkbox"/> IMAGING AND DIAGNOSTIC SERVICES REPORT | |
| <input type="checkbox"/> LABOR & DELIVERY NOTES | |
| <input type="checkbox"/> OP REPORT | |
| <input type="checkbox"/> PATHOLOGY REPORT | |

Any Questions, call MDCH Provider Inquiry: 1-800-292-2550

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